

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105998	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Winter Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Lake Alfred Rd Winter Haven, FL 33881	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768</p> <p>Based on record review and interview the facility failed to provide notification to the resident representative for one of six residents (Resident #106) sampled for accidents out of a total sample of 52 residents.</p> <p>Findings Included:</p> <p>Review of Resident #106's Admission Record showed an admitted [DATE], discharge date of [DATE] to an acute care hospital, and diagnoses to include urinary tract infection, osteoporosis, leukemia, hypertension, rheumatoid arthritis, muscle wasting and atrophy, difficulty walking, and repeated falls. Resident #106 had three family members listed as emergency contacts on the Admission Record.</p> <p>Review of the Change in Condition Evaluation dated 07/15/2024 at 2:43 a.m. showed Resident #106 fell on [DATE] at 2:20 a.m. Section 3. Resident/Representative Notification was blank.</p> <p>Review of the progress notes showed no documentation the family was called post fall on 07/15/2024.</p> <p>Review of the Situation, Background, Assessment, Recommendations (SBAR) dated 07/16/2024 showed Resident #106 was sent to the ER for treatment on 07/16/2024 at 12:20 a.m. The family was notified on 07/16/2024 at 7:00 a.m. about the 07/15/2024 at 2:20 a.m. fall and being sent to the ER.</p> <p>During an interview on 04/09/2025 at 2:26 p.m. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) it was confirmed Resident #106 fell on [DATE] at 2:20 a.m. The resident was assessed for the pain and neuro-checks were conducted. The resident stated she was getting ready for the day, and was reminded what time it was. The resident had no pain at the time of the fall and no injuries at that time were noted. The DON confirmed there was no documentation that the family was informed of the fall on 7/15/2024 at 2 a.m. She stated there was documentation the family was informed she was going to the hospital on 07/16/2024 after the resident expressed an increase in pain and x-rays revealed a left hip fracture. The DON stated the family should have been informed about the fall on 7/15/2024.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52245</p> <p>Based on interview, observation, and record review, the facility failed to maintain a safe, clean, and comfortable homelike environment in 16 out of 52 resident rooms and in three Wings/Common areas (100, 400 and 600) of six Wings toured.</p> <p>Findings included:</p> <p>On 4/8/2025 at 12:40 p.m., 4/9/2025 at 09:50 a.m., and on 4/10/2025 at 10:10 a.m. the following was observed:</p> <p>Resident room [ROOM NUMBER] was observed with bio growth on the ceiling at the fire sprinkler head.</p> <p>Resident room [ROOM NUMBER] was observed with a brown, rough surface over the toilet seat.</p> <p>Resident room [ROOM NUMBER] was observed with a brown, rough surface over the toilet seat.</p> <p>Resident room [ROOM NUMBER] was observed with bio growth on the ceiling at the fire sprinkler head.</p> <p>Resident room [ROOM NUMBER] was observed with unfinished walls near the TV and bio growth on the ceiling at the fire sprinkler head.</p> <p>Resident room [ROOM NUMBER] was observed without a call light pulling string in the bathroom.</p> <p>Resident room [ROOM NUMBER] was observed with broken drawers.</p> <p>Resident room [ROOM NUMBER] was observed with a brown, rough surface over the toilet seat.</p> <p>Resident room [ROOM NUMBER] was observed with no call light system in the bathroom.</p> <p>Resident room [ROOM NUMBER] was observed with a broken toilet.</p> <p>Resident room [ROOM NUMBER] was observed with pest feces in the shower.</p> <p>Resident room [ROOM NUMBER] was observed with a brown, rough surface over the toilet seat.</p> <p>Resident room [ROOM NUMBER] was observed with a brown, rough surface over the toilet seat, unpainted walls near the TV and baseboards missing near the air conditioner.</p> <p>Resident room [ROOM NUMBER] was observed with brown, rough surfaces in the bathroom walls and over the toilet seat.</p> <p>Resident room [ROOM NUMBER] was observed with no paint on the walls near the TV and no light in the bathroom.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident room [ROOM NUMBER] was observed with a brown, rough surface over the toilet seat, and no call light in the bathroom.</p> <p>Resident common areas in the 100 Wing were observed with bio growth on the ceiling near the nurses station in the sitting area.</p> <p>The common area in the 400 Wing was observed with bio growth on the ceiling near the nurses station and the ceiling tiles hanging loose in the sitting area.</p> <p>The 600 Wing hallway was observed with bio growth in the light at the end of the hallway and also near the sprinkler head in the same area.</p> <p>On 4/10/25 at 11:08 a.m. an interview was conducted with the Director of Maintenance (DOM). The DOM stated he walked the facility daily and if he saw an issue, he resolves it immediately or enters it into the electronic maintenance work order system. He stated the staff also enters issues into the electronic maintenance work order system, and he reviews the system for additions on a daily basis if not at least weekly. The DOM said, I do not do a comprehensive survey and submit it to the Nursing Home Administrator (NHA). The DOM stated he tries to get issues fixed immediately and if he can't get it accomplished, he has his assistant who fixes it and keeps a log with emails correspondence. The DOM stated he does not have a written policy regarding daily, weekly, monthly or annual maintenance. He stated it is directed through the electronic maintenance work order system. The DOM stated he did not have a bio growth policy. He stated if he suspected bio growth, he would clean the area and watch it.</p> <p>Review of an undated facility document titled, Patch and paint revealed twenty-two resident room walls were patched without paint.</p> <p>Review of an undated facility document titled, electronic maintenance work order system task manager, did not show a task manager for maintenance of walls, floorboards or resident equipment was in place.</p> <p>Review of an undated facility document titled, Work Orders showed no orders addressing the walls or floorboards or bio growth or the falling ceiling.</p> <p>Review of a facility policy titled, Routine Cleaning and Disinfection policy, dated 9/2023 Reviewed by Clinical Services, showed it is the policy of this facility to ensure the provision of routine cleaning and disinfection to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Cleaning refers to the removal of visible soil from objects and surfaces, transmission-based precautions refers to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled.</p> <p>Photographic evidence obtained.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48223</p> <p>Based on observation, interview, and record review, the facility failed to provide grooming assistance of shaving facial hair for four (#5, #14, #33, #46) of six residents sampled for activities of daily living (ADL).</p> <p>Findings included:</p> <p>1. On 04/08/25 at 02:35 PM, Resident #5 was observed in Resident Council meeting with several white hairs about 1/4 inch in length on her chin.</p> <p>During an interview on 04/08/25 at 05:07 PM, Resident #5 stated she did not like the facial hair and hoped the facility would assist in removal. The resident stated they don't ask me.</p> <p>Review of the Certified Nursing Assistant (CNA) ADL task report for Resident #5 for the month of April 2025 revealed documentation did not reflect any instances of this resident refusing care and showed ADL care was provided.</p> <p>Review of Resident #5's care plan dated 1/25/25 revealed Resident #5 required supervision or touching assistance with personal and oral hygiene and partial moderate assistance on bathing/showering.</p> <p>2. On 04/07/25 at 10:20 AM, Resident #14 was sleeping in bed with two patches of approximately 1/2 inch gray hair patches on each side of her chin.</p> <p>During an interview on 04/07/25 at 02:00 PM, the Resident Representative (RR) for Resident #14 stated the resident would not want to have whiskers; what lady wants to have whiskers? The RR said she wished the facility would take care of this.</p> <p>On 04/08/25 at 12:25 PM, Resident #14 was sitting up in the wheelchair with her lunch meal and still had the two patches of approximately 1/2 inch gray hair on each side of her chin.</p> <p>Review of the CNA ADL task report for Resident #14 for the month of April 2025 revealed documentation did not reflect any instances of this resident refusing care and showed ADL care was provided.</p> <p>Review of Resident #14's care plan dated 2/12/25 revealed Resident #14 required maximum assistance with oral hygiene and was dependent on bathing/showering. The resident had no care plan for any behaviors/rejection of care.</p> <p>3. During an observation on 04/07/2025 at 10:16 a.m., Resident #33 was observed to have small patches of white hair protruding from her chin.</p> <p>During an observation on 04/08/2025 at 12:19 p.m., Resident #33 was observed having the same small patches of white hair protruding from her chin.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #33's active care plans revealed no care plans for rejection of ADL care. Review of Resident #33's ADL care plan dated 3/21/2025 revealed the resident required partial/moderate assistance with bathing/showering; provide sponge bath when a full bath/shower cannot be tolerated.</p> <p>Review of Resident #33's CNA ADL task report for the month of April 2025 revealed documentation did not reflect any instances of this resident refusing care and showed ADL care was provided.</p> <p>4. During an observation on 04/07/2025 at 12:19 p.m., Resident #46 was observed to have a white patch of hair protruding from her chin.</p> <p>During an observation on 04/08/2025 at 9:23 a.m., Resident #46 was observed with a patch of white hair protruding from her chin.</p> <p>Review of Resident #46's CNA ADL task report for the month of April 2025 revealed documentation did not reflect any instances of this resident refusing care and showed ADL care was provided.</p> <p>Review of Resident #46's care plan initiated 8/19/22 revealed Resident #46's facial hair will be removed as desired, requires assistance of 1 with oral and personal hygiene and was dependent on staff for bathing/showering. The care plan did show behaviors of refusing showers, but did not document refusal of personal grooming.</p> <p>During an interview on 04/08/25 at 3:03 PM Staff W, CNA stated if a female resident has facial hair, we (staff) should shave them.</p> <p>During an interview on 04/08/25 at 4:10 PM Staff Y, CNA stated facial grooming was completed daily during morning care, and during bath/shower days. This included, male and female residents. Staff Y, CNA stated females should not have facial hair. We should shave them.</p> <p>During an interview on 04/08/25 at 4:53 PM Staff R, Licensed Practical Nurse (LPN) stated that ADL care was completed at least in the morning. ADL care included facial grooming. Female residents should not have whiskers. Staff R, LPN was not aware of any female residents who refused facial grooming.</p> <p>During an interview on 04/08/25 at 4:55 PM Staff AA, LPN Unit Manager stated ladies facial grooming should be included with ADL care. Staff AA, LPN did not know of any female residents who wanted facial hair and was unaware of any residents refusing to have facial hair removed.</p> <p>During an interview on 04/08/25 at 5:00 PM the Director of Nursing (DON) stated ADL care was all encompassing of general hygiene to include facial grooming (for both males and females). The DON reported if the resident does not want to have facial hair, it should be shaved. The DON said the resident's preference should be care planned and if the resident has behavior of refusing care, this should be care planned. The DON stated the expectation would be for resident's preferences to be followed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policies and procedures titled Grooming a Resident's Facial Hair with a revision date of 7/1/2024 revealed: Policy: It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice. Policy Explanation and Compliance Guidelines: 5. When the facial hair is covered with shaving cream and softened, begin shaving. Shave in the direction that the hair grows. Hold the skin taut and smooth by pulling the skin upward with one hand and shaving with a downward stroke with your other hand. Use short, even strokes. Be particularly careful with the neck, chin, and upper lip. Use upward strokes for the neck, downward and slightly diagonal strokes for the chin, and very short downward strokes above the lip. 8. Allow the resident to look in a mirror to make sure they are satisfied with their appearance.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews the facility failed to reconcile, obtain, and provide medications as ordered, for two residents (#105 and #53) of five residents sampled for admissions/readmissions.</p> <p>Findings included:</p> <p>1. Review of Resident #105's Admission Record showed the resident was admitted on [DATE]. The primary admitting diagnosis was other seizures, with other diagnoses of unspecified benign neoplasm of brain, epileptic seizures related to external causes not intractable without status epilepticus, myasthenia gravis without (acute) exacerbation, and chronic pain syndrome.</p> <p>Review of Resident #105's Admission/Readmission Nursing Evaluation, dated 11/19/24 at 4:08 a.m., revealed the resident's medications and physician orders had been reviewed and the resident had arrived via stretcher from a hospital for seizure activity and pain history (hx) left shoulder Arthropathy. The evaluation did not reveal an order had been received from the physician to administer medications when they became available.</p> <p>Review of Resident #105's discharge medications, dated 11/19/24 at 9:53 a.m. from the acute care facility, the following scheduled medications were ordered with the times the next dose was due:</p> <ul style="list-style-type: none"> - Butalbital-acetaminophen-caffeine 50-325-40 milligram (mg) - Take 1 tablet by mouth in the morning and 1 tablet before bedtime. Next dose: 11/9/24 at 9:00 p.m. - Carvedilol 6.25 mg - Take 1 tablet by mouth in the morning and 1 tablet in the evening. Take with meals. Next dose: 11/19/24 at 7 p.m. - Clotrimazole-betamethasone - apply 1 application topically in the morning and 1 application before bedtime. Next dose 11/19/24 at 9:00 p.m. - Doxepin 100mg - Take 1 capsule (100 mg) by mouth every night. Next dose 11/19/24 at 9:00 p.m. - Gabapentin 300 mg - Take 1 capsule by mouth in the morning and 1 capsule at noon, and 1 capsule before bedtime. Next dose: 11/19/24 at 9 p.m. - Glucosamine 200 mg - Take 1 tablet by mouth in the morning and 1 tablet before bedtime. Next dose: 11/19/24 at 9 p.m. - Lamotrigine 100 mg - Take 1 tablet by mouth in the morning and 1 tablet before bedtime. Next dose: 11/19/24 at 9:00 p.m. - Magnesium oral (PO) - Take 1 tablet by mouth one time a day. Strength per over-the-counter product labeling. Next dose: 11/20/24 at 9 a.m. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Melatonin PO - Take 1 tablet by mouth every night. Strength per over-the-counter product labeling. Next dose: 11/19/24 at 9 p.m.</p> <p>- Olmesartan-hydrochlorothiazide (Benicar HCT) 40-12.5 mg - Take 1 tablet by mouth each day. Next dose 11/20/24 at 9:00 a.m.</p> <p>- Potassium gluconate 595 mg - Take 1 tablet by mouth one time a day. Next dose: 11/20/24 at 9:00 a.m.</p> <p>- Quetiapine (Seroquel) 300 mg - Take 1 tablet by mouth every night. Next dose: 11/19/24 at 9 p.m.</p> <p>- Rexulti 1 mg - Take one tablet by mouth one time a day. Next dose 11/20/24 at 9:00 a.m.</p> <p>- Tizanidine 4 mg - Take 1 capsule by mouth in the morning and 1 capsule at noon and 1 capsule before bedtime. Next dose: 11/19/24 at 9 p.m.</p> <p>- Trazodone 150 mg - Take 1 tablet by mouth every night. Next dose 11/19/24 at 9:00 p.m.</p> <p>- Vitamin C (PO) - Take 1 tablet by mouth one time each day. Next dose: 11/20/24 at 9:00 a.m.</p> <p>Review of the pharmacy Delivery & Cut-off Times showed Monday - Friday new order cut off times were 11:00 a.m. with a departure time (from pharmacy) of 2:00 p.m. and 8:00 p.m., for new admissions the cutoff time was 10:00 p.m. with a departure time of 2:00 a.m. The information revealed if a refill was needed immediately, please contact pharmacy and if something was faxed after cutoff and needed to be received staff were to call the pharmacy immediately.</p> <p>Review of Resident #105's progress notes showed medication orders for Carvedilol, Doxepin, Glucosamine, Oxycodone, Potassium Gluconate, Quetiapine Fumarate, Rexulti, Tizanidine, and Trazodone had been entered on 11/19/24 at 3:46 p.m. The notes showed possible interactions between medications with the following orders (for) Butalbital-acetaminophen-Caffeine, Clonidine, and Benicar.</p> <p>Review of Resident #105's November Medication Administration Record (MAR) revealed the following:</p> <p>- Butalbital-acetaminophen-caffeine 50-325-40 milligram (mg) - Give 1 tablet by mouth three times a day for chronic pain syndrome. Started on 11/19/24 at 9:00 p.m., scheduled for 9:00 a.m., 12:00 noon, and 9:00 p.m. The MAR showed the resident did not receive the dose scheduled for 11/19 at 9:00 p.m. and doses scheduled on 11/20 at 9:00 a.m. and 12:00 noon, missing 3 doses.</p> <p>- Carvedilol 6.25 mg - Give 1 tablet by mouth one time a day for transient ischemic attack (TIA). Started on 11/20 and scheduled for 9:00 a.m. The MAR showed the resident did not receive the scheduled dose on 11/20/24, missing one dose.</p> <p>- Clotrimazole-betamethasone External cream 1-0.05% - Apply to affected area topically two times a day for rash. Started on 11/19/24 at 9:00 p.m. and scheduled for 9:00 a.m. and 9:00 p.m. The MAR showed the resident did not receive on 11/19 at 9:00 p.m. or on 11/20 at 9:00 a.m., missing 2 doses.</p> <p>- Doxepin 100mg - Give 1 capsule by mouth one time a day for prophylactic. Started on 11/20 at 9:00 p.m. Per the discharge medication list the resident was to receive a dose on 11/19 at 9:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Gabapentin 300 mg - Give 1 capsule three times a day for neuropathy. Started on 11/19/24 at 9:00 p.m. and scheduled for 8:00 a.m., 12:00 noon, and 9:00 p.m. The MAR showed the resident did not receive the scheduled dose for 11/19 at 9:00 p.m. or the 8:00 a.m. dose on 11/20/24, missing two doses.</p> <p>- Glucosamine 200 mg - Give 1 tablet by mouth two times a day for seizures. Started on 11/19/24 at 9:00 p.m. and scheduled for 9:00 a.m. and 9:00 p.m. The MAR showed the resident did not receive the 9:00 p.m. dose on 11/19 or the 9:00 a.m. dose on 11/20, missing 2 doses.</p> <p>- Lamotrigine 100 mg - Give 100mg by mouth two times a day for seizures. Started on 11/19 at 9:00 p.m. and scheduled for 9:00 a.m. and 9:00 p.m. The MAR showed the resident did not receive the 9:00 p.m. dose on 11/19 or the 9:00 a.m. dose on 11/20, missing 2 doses.</p> <p>- Magnesium 400 mg - Give 1 tablet by mouth one time a day for supplement. Started on 11/20 at 9:00 a.m. The MAR showed the resident did not receive the 11/20 dose, missing one dose.</p> <p>- Melatonin 3 mg - Give 1 tablet by mouth one time a day for insomnia. Started on 11/20/24. Per the discharge medication list the resident was to receive a dose on 11/19 at 9:00 p.m.</p> <p>- Olmesartan-Hydrochlorothiazide (Benicar HCT) 40-12.5 mg - Give 1 tablet by mouth one time a day for hypertension. The order started on 11/20/24 at 9:00 a.m. The MAR showed the resident did not receive on 11/20 and staff documented on 11/21 Awaiting arrival from pharmacy. The resident missed two doses.</p> <p>- Potassium gluconate 595 mg - Give 1 tablet by mouth one time a day for supplement. Started on 11/20/24 and scheduled 11/20 at 9:00 a.m. The MAR showed the resident did not receive on 11/20 and staff documented on 11/21 Awaiting arrival from pharmacy. The resident missed two doses.</p> <p>- Quetiapine (Seroquel) 300 mg - Give 1 tablet by mouth one time a day for depression. Started on 11/20 at 9:00 a.m. The MAR showed the resident did not receive a dose on 11/20, missing one dose.</p> <p>- Rexulti 1 mg - Give 1 tablet by mouth one time a day for seizures. Started on 11/20/24 at 9:00 a.m. The MAR showed the resident did not receive a dose on 11/20.</p> <p>- Tizanidine 4 mg - Give 1 tablet by mouth three times a day for muscle spasms. Started on 11/19/24 at 9:00 p.m. and scheduled for 9:00 a.m., 1:00 p.m., and 9:00 p.m. The MAR showed the resident did not receive the 9:00 p.m. dose on 11/19 or the 9:00 a.m. dose on 11/20, missing two doses. The resident also did not receive the 1:00 p.m. dose on 11/21, and 11/27.</p> <p>- Trazodone 150 mg - Give 1 tablet by mouth one time a day for depression. Started on 11/20 at 9:00 p.m. The MAR showed the resident did not receive the dose on 11/20, missing one dose.</p> <p>- Ascorbic Acid (Vitamin C) - Give 1 tablet by mouth one time a day for supplement. Started on 11/20 at 9:00 a.m. The MAR showed the resident did not receive the dose on 11/20, missing one dose.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25 at 10:25 a.m. the Director of Nursing stated the policy (regarding missing medications) was to get an order to hold or call the pharmacy to see how quickly it can arrive, or to get an order to administer (medications) when it arrives. She stated the facility could get over-the-counter (OTC) from a local drug store and staff should retrieve from central supply or the electronic dispenser if the medication was not available on the cart.</p> <p>An interview was conducted on 4/10/25 at 3:57 p.m. with the DON. The DON stated physicians would need to be notified if the medication was not available and should have documentation related to why the medication was not given and the physician was notified in either a nursing note or a medication administration note. She described the process for new admissions was medications were ordered upon admission, in morning meeting the team reviews orders to ensure they were transcribed correctly, the orders goes straight to pharmacy (when ordered) and if they are put in on time (scheduled out of time) they would arrive on the next (pharmacy) drop.</p> <p>Review of the list of medications available in the electronic dispenser revealed the following medications were stocked (on 4/8/25):</p> <ul style="list-style-type: none"> - Carvedilol 3.125 mg tablets - Gabapentin 300 mg capsules - Quetiapine 25 mg tablets <p>Review of the list of House Stock medications, provided by the facility, revealed the facility did not stock over-the-counter Vitamin C, Magnesium or the sleep aid Melatonin.</p> <p>2. Review of Resident #53's Admission Record revealed the resident was originally admitted on [DATE] and readmitted on [DATE]. The record showed the resident's primary diagnosis was unspecified chronic obstructive pulmonary disease, unspecified diabetes mellitus due to underlying condition with diabetic neuropathy, type 1 diabetes mellitus, unspecified respiratory failure with hypercapnia, unspecified heart failure, essential (primary) hypertension, and unspecified systolic (congestive) heart failure.</p> <p>Review of Resident #53's Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form showed the resident was transferred on 4/5/25 at 3:06 p.m. to an acute care facility without a listed reason for the transfer.</p> <p>On 4/9/25 at 9:11 a.m. an observation was conducted with Staff E, LPN of medication administration for Resident #53. The staff member reported not knowing how long the resident had been in the hospital but was coming back when the staff member was leaving on 4/8/25 at approximately 4:30 p.m. The observation revealed the staff member writing numerous medications on the report sheet. Staff E administered Baclofen, Gabapentin, Venlafaxine, Cetirizine, Sucralafate, metoprolol Tartrate, ferrous and Spiriva inhaler. The staff member confirmed dispensing 8 oral medications, one liquid, and one inhaler. The resident complained of hurting so bad and asked the staff member for Zofran, Staff E looked in cart for the requested medication and stated it would have to be re-ordered. The staff member informed Staff D, Registered Nurse/Unit Manager (RN/UM) of missing all these showing the report sheet.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the pharmacy Delivery & Cut-off Times showed Monday - Friday new order cut off times were 11:00 a.m. with a departure time (from pharmacy) of 2:00 p.m. and 8:00 p.m., for new admissions the cutoff time was 10:00 p.m. with a departure time of 2:00 a.m. The information revealed if a refill was needed immediately, please contact pharmacy and if something was faxed after cutoff and needed to be received staff were to call the pharmacy immediately. Based on the interview with Staff E, Resident #53's revealed the resident was readmitted prior to the last cutoff time of 10:00 p.m. and medications would have left the pharmacy at 2:00 a.m. and if a refill was needed immediately staff were to contact the pharmacy.</p> <p>Review of Resident #53's April Medication Administration Record (MAR) revealed Staff E had documented the following medications were not administered:</p> <ul style="list-style-type: none"> - Aldactone (Spironolactone) 25 mg - Give 1 tablet by mouth one time a day for Hold for systolic blood pressure (SBP) <100 related to unspecified heart failure. - Azithromycin 250 mg - Give 1 tablet by mouth one time a day for infections for 3 days. This order was new with a start date of 4/9/25. - Empagliflozin 10 mg - Give 1 tablet by mouth one time a day related to Type 1 diabetes mellitus without complications. - Lamotrigine 200 mg - Give 1 tablet by mouth one time a day for mood disorder (d/o). - Lisinopril 10 mg - Give 1 tablet by mouth one time a day related to essential (primary) hypertension. - Potassium Chloride Extended Release (ER) 20 milliequivalent's (meq) - Give 1 tablet by mouth one time a day for congested heart failure (CHF). - Prednisone 20 mg - Give 2 tablets by mouth one time a day for pain for 2 days. This order was new with a start date of 4/9/25. - Spironolactone 50 mg - Give 1 tablet by mouth one time a day for CHF. - Zofran 4 mg - Give 4 mg by mouth every 6 hours as needed for nausea (and) vomiting. The order started on 1/13/25. <p>Review of Resident #53's progress notes showed Staff E had documented the medications: Azithromycin, Empagliflozin, Potassium chloride, Lisinopril, Lamotrigine, Aldactone, Spirolactone, and Prednisone were on order. The notes did not show the pharmacy or physician was notified of the medications not being available.</p> <p>Review of the electronic medication dispenser list, dated 4/8/25 at 9:49 a.m. showed the facility had the following medications available:</p> <ul style="list-style-type: none"> - Azithromycin 250 mg tablets - 13 tablets available. - Lisinopril 5 mg tablets - 12 tablets available. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Potassium chloride ER 10 meq tablets - 14 tablets were available</p> <p>- Prednisone 5 mg tablets - 20 tablets available.</p> <p>- Ondansetron (Zofran) oral disintegrating tablet (ODT) 4 mg tablets - 5 tablets were available.</p> <p>During an interview on 4/9/25 at 10:02 a.m. Staff E, Licensed Practical Nurse (LPN) reported the policy for missing medications was to call the pharmacy and the physician. The staff member reported having to call the pharmacy as some of the medications said they were on order.</p> <p>Review of the policy - Medication Administration, reviewed and revised 9/1/23, showed the following:</p> <p>Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy showed If any medication is not available, or the possibility of late administration, the nurse will contact the Attending Physician.</p> <p>Review of the policy - Pharmacy Services, reviewed/revised 1/2025, revealed the following:</p> <p>It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The compliance guidelines included:</p> <p>1. The facility will provide pharmaceutical services to include procedures that usher they're accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements and reflect current standards of practice.</p> <p>Review of the policy - Medication Reconciliation, reviewed/revised 1/2025, revealed the following:</p> <p>This facility reconciles medication frequently throughout a resident state to ensure that the resident is free of any significant medication errors, and that the facilities medication error rate is less than 5%.</p> <p>3. Pre admission Processes:</p> <p>a. Obtain current medication list from referral source (i.e. Hospital, home health, Hospice, or primary care provider).</p> <p>b. Obtain current medication/ admission orders.</p> <p>c. Verify resident identifiers.</p> <p>d. Forward to nursing unit accepting the resident.</p> <p>4. Admission processes:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Verify resident identifiers on the information received.</p> <p>b. Compare orders to hospital records, etcetera. Obtain clarification orders as needed.</p> <p>c. Transcribe orders in accordance with procedures for admission orders.</p> <p>d. Order medications from pharmacy in accordance with facility procedures for ordering medications.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure the medication error rate was less than 5.00%. Forty-one medication administration opportunities were observed, and fourteen errors were identified for four residents (#40, #98, #93, and #53) of six residents observed. These errors constituted a 34.15% medication error rate.</p> <p>Findings included:</p> <p>1.</p> <p>On [DATE] at 8:24 a.m. an observation of medication administration with Staff P, Licensed Practical Nurse (LPN) was conducted with Resident #40. The staff member searched medication cart for a bottle of Calcium 500 milligram(mg) tablets. Staff P went to the central supply office cupboard and retrieved an over-the counter bottle before revealing the bottle was Calcium with Vitamin D and not the medication the resident was ordered. The staff member proceeded to dispense the following:</p> <ul style="list-style-type: none"> - Carvedilol 3.125 mg tablet - Furosemide 40 mg tablet - Jardiance 10 mg tablet - Lisinopril 40 mg tablet <p>Staff P confirmed dispensing four (4) tablets prior to administering the medications to Resident #40. The staff member informed the resident of owing him one calcium (tablet).</p> <p>Review of Resident #40's April Medication Administration Record (MAR) showed an order dated [DATE] for Calcium Oral Tablet - Give 500 mg by mouth one time a day for supplement. The MAR revealed the resident had received 500 mgs of Calcium per the physician order daily from ,d+[DATE] - [DATE]. The Director of Nursing (DON) had documented 5 on [DATE], which according to the legend Hold/See progress note. The MAR revealed the order for 500 mgs of Calcium had been discontinued on [DATE] at 9:33 a.m. and a different order was written for one tablet of Calcium 600/Vitamin D 10 microgram (mcg) to be administered one time a day for vitamin (vit) deficiency (def). The order for Calcium with Vitamin D was to start on [DATE] at 10 a.m. Review of a progress note written on [DATE] at 9:35 a.m. (1 hour 11 minutes after observation) showed the order for 500 mg of Calcium had been updated per the physician had changed the order to Calcium 600/Vit D 10 mcg.</p> <p>2.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 4:06 p.m. an observation of medication administration with Staff Q, Licensed Practical Nurse (LPN) was conducted with Resident #98. The staff member removed the resident's glucometer and a blood pressure machine from the medication cart. The glucometer was used to obtain the resident's blood glucose level of 414 and a blood pressure of ,d+[DATE] was obtained. Staff Q removed from the top drawer of the medication cart a clear plastic bag containing a box, which the staff member removed a vial of Insulin Lispro. The plastic bag revealed the vial had been opened on ,d+[DATE] and a handwritten date revealing the insulin had expired on [DATE]. The staff member stated the insulin was good for one month and should still be good then looked at the date and confirmed it had expired on [DATE]. Staff Q searched medication cart and was unable to locate another Insulin Lispro vial or pen for Resident #98. The staff member observed the unit's medication refrigerator and reported the resident did not have any extra Humalog. The staff member returned to the medication cart and dispensed one 2.5 milligram (mg) tablet of Midodrine into a medication cup and handed it to the resident. The Midodrine blister card label had parameters to hold for systolic >140. The staff member was asked to stop, take cup back from resident, and review the physician order. Staff Q read the order aloud and stated she should not give the Midodrine but was going to contact the physician and verify the order as she felt it was wrong due to the medication was for low blood pressure.</p> <p>As the pharmacy delivery was standing at the nursing station during the observation with Staff Q, she stated she was going to check and see if Resident #98's Humalog was included in the delivery (which it was not). The staff member returned to the unit's medication refrigerator and removed an Insulin Lispro Kwikpen from the Emergency Drug Kit (EDK), labeling it with the resident's name and the date it was opened. The staff member returned to the resident's room, placed needle on pen, dialing the dosage selector to 16 units, saying one unit was used to prime the pen because it was new. Staff Q stood in front of the resident's trash can, pointed the needle end of the pen downwards and pushed the dosage selector, dialed the pen to 15 units and injected the resident in the right lower abdominal quadrant. The staff member called physician who confirmed the Midodrine order was correct, and it was to be held for a blood pressure greater than 140.</p> <p>An interview was conducted with Staff Q on [DATE] at 5:08 p.m. The staff member stated she was not going to administer the Midodrine because she was thinking about it. Then after discussing the observation, the staff member admitted that she was going to administer the Midodrine prior to being asked to stop. The staff member reported she had been educated to prime the insulin pens with one unit to get rid of the air bubble. She confirmed by holding the pen with the needle downwards the air bubble would have been toward the top of insulin cartridge and the air bubble would not have been removed.</p> <p>Review of Resident #98's April Medication Administration Record (MAR) revealed an order for Midodrine 2.5 mg - Give 1 tablet by mouth three times a day for dizziness/low blood pressure (BP), hold for systolic BP greater than (>) 140.</p> <p>Review of policy/procedure - Insulin Pens, implemented ,d+[DATE] revealed it was the policy of the facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self administration of insulin therapy upon discharge. The compliance guidelines described Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. The procedure revealed staff to prime the insulin pen by</p> <p>- Dial 2 units by turning the dose selector clockwise.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- With the needle pointing up, push the plunger, and watch to see at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears.</p> <p>3.</p> <p>On [DATE] at 5:37 p.m. an observation of medication administration with Staff R, Licensed Practical Nurse (LPN) was conducted with Resident #93. The staff member dispensed the following:</p> <p>- Magnesium Oxide 400 milligram (mg) over the counter (OTC) tablet</p> <p>Staff R confirmed the resident was to receive a tablet of Citalopram but it hadn't arrived so she had documented a progress note. The staff member confirmed one tablet had been dispensed.</p> <p>Review of Resident #93's April Medication Administration Record (MAR) revealed the resident was to receive Celexa (Citalopram Hydrobromide) 10 milligram (mg) tablet - give 1 tablet by mouth in the evening for depression (start date [DATE]). The record showed Staff R had documented 9 (per legend = other/see progress notes).</p> <p>4.</p> <p>On [DATE] at 9:11 a.m. an observation of medication administration with Staff E, Licensed Practical Nurse (LPN) was conducted with Resident #53. The staff member dispensed the following medications:</p> <p>- Baclofen 10 milligram (mg) tablet</p> <p>- Gabapentin 600 mg tablet</p> <p>- Venlafaxine Extended Release (ER) 75 mg - 3 capsules</p> <p>- Cetirizine 10 mg over the counter (OTC) tablet</p> <p>- Sucralfate 1 gram(gm)/10 milliliter (mL) oral suspension - 10 mL's</p> <p>- Ferrous sulfate 325 mg OTC tablet</p> <p>- Spiriva Respimat 2.5 mg actuation inhalation</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The staff member searched the bottom drawer of medication cart for additional medications before writing Lamotrigine, Lisinopril, potassium, Prednisone, Spirolactone, Aldactone, and Jardiance on report sheet. Staff E asked resident about taking Miralax or Lactulose, which the resident refused both and the staff member stated the resident had also refused the inhaler Anoro. The resident complained of pain and the staff member stated the resident's hydrocodone ,d+[DATE] mg tablets were not available. Staff E confirmed dispensing 8 oral medications, one liquid, and one inhaler. The resident asked the staff member for Zofran, which after looking in locked narcotic box in drawer of medication cart, Staff E reported it was not available and reordered it. Staff E reported to Staff D, Registered Nurse/Unit Manager (RN/UM) the resident did not have all these showing her the medications written on the report. Staff D stated the resident had just returned from the hospital, providing a blister card of hydrocodone/acetaminophen ,d+[DATE] mg tablets, reporting the hospital had changed it but physician had okayed for the resident to receive prior ordered narcotic.</p> <p>Review of Resident #53's MAR revealed Staff E had documented 9 - other/see progress notes on [DATE] during the time of the observation for the following medications:</p> <ul style="list-style-type: none"> - Aldactone (Spironolactone) 25mg - one time a day - Azithromycin 250 mg - one time a day for infection for 3 days - Empagliflozin 10 mg - one time a day for Type 1 Diabetes Mellitus - Lamotrigine 200 mg tablet - one time a day - Lisinopril 10 mg - one time a day - Potassium Chloride ER 20 meq - Prednisone 20 mg - give 2 tablets for pain for 2 days - Spironolactone 50 mg <p>The MAR showed Staff E had administered one 100 mg capsule of Colace, which was not observed or accounted for during the confirmation of the number of oral medications.</p> <p>Review of a list of medications available in the electronic dispenser, as of [DATE] at 9:49 a.m., the following medications were available:</p> <ul style="list-style-type: none"> - Azithromycin 250 mg - 13 tablets were on hand - Lisinopril 5 mg - 12 tablets were on hand - Potassium Chloride ER 10 meq - 14 tablets were on hand - Prednisone 5mg - 20 tablets were on hand <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #53's progress notes showed the resident had been transferred to hospital on [DATE] at 8:00 a.m. during shift change. The progress notes revealed on [DATE] the resident continued to be hospitalized. The notes did not reveal staff had documented when the resident had returned from the hospital or had assessed the resident upon return. The MAR revealed empty spaces and hospitalization codes from [DATE] until the scheduled dose of Insulin Aspart at 4:00 p.m. on [DATE] when the resident had received 6 units for a blood sugar of 202.</p> <p>During an interview on [DATE] at 10:02 a.m. Staff E stated she did not know how long Resident #53 had been in hospital, but she was coming in when the staff member was leaving ([DATE] at approximately 4:30 p.m.). The staff member stated the policy for missing (unavailable) medications were to call the pharmacy and the physician. She stated some of the medications said they were on order.</p> <p>Review of the pharmacy Delivery & Cut-off Times showed Monday - Friday new order cut off times were 11:00 a.m. with a departure time of 2:00 p.m. and 8:00 p.m. with a departure time of 2:00 a.m., for new admissions the cutoff time was 10:00 p.m. with a departure time of 2:00 a.m. The information revealed if a refill was needed immediately, please contact pharmacy and if something was faxed after cutoff and needed to be received staff with to call the pharmacy immediately.</p> <p>During an interview on [DATE] at 10:25 a.m. the Director of Nursing (DON) stated the procedure for unavailable medications was to either get an order to hold the medication, to call pharmacy to see how quickly it could arrive, or an order to administer it when it arrived, regarding over-the-counter medications, the facility can get them from local drug store. The DON reported staff should retrieve medications from central supply or the electronic dispenser if the medication was not available on the cart. She reported an order can be changed per the physician discretion, if the doctor felt it more beneficial to the resident the order can be changed. In regards to Resident #40, the DON stated the medical director was here, assessed the resident, and felt changing the medication to Calcium with Vitamin D was appropriate, however Calcium 500 mg tablets should have been available. She stated typically medications should be re-ordered within a week, for a re-admission (Resident #53) the hospital will give orders, staff reconcile them, and if the medications were held in the medication room, staff were to return them to the cart, if they had been sent back they would arrive on the next delivery. The DON stated medications for Resident #53 probably missed the cutoff time but would have arrived on this morning's run. Reviewed list of medications available in electronic dispenser with the DON, who was surprised Citalopram (Resident #93) was not available but felt it was strange it wasn't available one day, administered for 4 days, then not available on the 5th day.</p> <p>An interview was conducted with the DON on [DATE] at 3:57 p.m. The DON reported physicians would need to be notified when the medication was not available.</p> <p>Review of the policy - Medication Administration, reviewed/ revised [DATE], revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>- 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.</p> <p>- 12. Identify expiration date. If expired, notify nurse manager.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105998	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Winter Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Lake Alfred Rd Winter Haven, FL 33881	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 14. Administer medication as ordered in accordance with manufacturer specifications.</p> <p>- 15. If any medication is not available, or the possibility of late administration, the nurse will contact the attending physician.</p> <p>- 18. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.</p> <p>Review of the policy - Medication Reconciliation, reviewed/revise ,d+[DATE], revealed this facility reconciles medication frequently throughout a resident state to ensure that the resident is free of any significant medication errors, and that the facilities medication error rate is less than 5%.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>20536</p> <p>52245</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on interview, observation, and record review, the facility failed to maintain an effective pest control management system in nine rooms (100, 103, 108, 106, 207, 210, 303, 410, and 604) out of 52 rooms toured, and for one resident (#78) of one resident sampled.</p> <p>Findings included:</p> <p>On 4/9/2025 at 12:45 p.m. and on 04/10/2025 at 10:10 a.m., observations were made of live crawling bugs and what appeared to be insect feces in resident rooms and common areas. The rooms included rooms 100, 103, 108, 106, 207, 210, 303, 410, and 604, and common areas of the 400 Wing.</p> <p>On 4/7/2025 at 11:00 a.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). She stated she had seen pests throughout the entire facility.</p> <p>On 4/10/2025 at 11:08 a.m., an interview was conducted with the Director of Maintenance (DOM). The DOM said, he walked the facility daily and if he saw an issue he resolved it immediately or entered it into the electronic maintenance work order system. The staff also entered issues into an electronic maintenance work order system, and he reviewed the system for additions on a daily basis if not at least weekly. The DOM said, I do not do a comprehensive survey and submit it to the Nursing Home Administrator (NHA). The DOM stated he tried to get issues fixed immediately and if he could not get it accomplished, he had his assistant who fixes it and keeps a log with emails. The DOM stated that he does not have a written policy regarding daily, weekly, monthly or annual maintenance, and it's directed through the electronic maintenance work order system. The DOM stated that the pest control schedule is for two times a month and if he sees a repetitive cycle, he will defer to the contractor. The DOM also stated that he has a background in Pest Control.</p> <p>On 4/7/2025 at 10:12 a.m. an interview was conducted with Resident #78. The resident stated that she has had multiple sightings of roaches and ants throughout her room and pointed out what appeared to be pest droppings under her nightstand.</p> <p>Review of a facility document titled the Pest Control Service Agreement dated, 2/12/2024 showed the Service Agreement states, during the term of this Agreement, (names pest control company), will provide the pest management services, described in a Service Specifications attached hereto and incorporated herein as Exhibit A-Client Proposal & Specifications (the Service Specifications). Covered pests: Mice, Rats, Ants and Roaches. Common areas, kitchen and exterior perimeters are included in the program.</p> <p>Initial service includes installation of equipment, logbook, map creation, inspection and spot treatments as needed. Schedule of one time and biweekly maintenance noted in agreement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105998	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Winter Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Lake Alfred Rd Winter Haven, FL 33881	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility document titled, pest log, for wings 100, 200 and 300 showed roaches were noted on: 12/3/2024, 12/30/2024, 12/31/2024, 1/3/2025, 1/11/2025, 2/22/2025, 3/20/2025, 3/20/2025, 3/11/2025, 3/11/2025, and 4/2/2025. Ants were noted on: 2/8/2025, 2/8/2025, 2/8/2025, 3/14/2025. Flies were noted on 2/4/2025 and spiders were noted on 4/2/2025.</p> <p>Review of a facility document titled pest log for wings 400, 500 and 600 showed roaches were noted on 9/24/2024, 10/27/2024, 12/23/2024, 12/30/2024, 1/14/2025, 2/5/2025, 2/24/2025, 4/2/2025, and 4/9/2025. Ants were noted on: 11/23/2024, 12/13/2024. Fleas were noted on: 2/5/2024. Pests were identified by a resident on: 3/7/2025.</p> <p>Review of a facility document titled, Pest Control Program Policy, dated 9/2023, reviewed by the administration stated it is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Definition of Effective pest control program is defined as measure to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats). Policy explanation and compliance guidelines:</p> <ol style="list-style-type: none"> 1. Facility will maintain written agreement with a qualified outside pest service. 2. Facility will ensure appropriate chemicals are used. 3. Facility will maintain a report system of issues that may arise 4. Facility will utilize a variety of methods in controlling pests. 5. Facility will ensure that the outside pest service also treats the exterior perimeter. <p>Photographic Evidence Obtained.</p>		